

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366363	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/07/2025
NAME OF PROVIDER OR SUPPLIER Laurels of Steubenville The		STREET ADDRESS, CITY, STATE, ZIP CODE 500 Stanton Boulevard Steubenville, OH 43952	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, medical record review, and interview, the facility failed to ensure orders were implemented for fall interventions for one (Resident #1) of three residents reviewed for falls. Findings include: Review of Resident #1's open medical record revealed diagnoses including generalized muscle weakness, difficulty walking, hypertensive heart disease, major depressive disorder, solitary pulmonary nodule, aneurysm of the ascending aorta, fatty liver, diverticulosis, and affective mood disorder. Review of Resident #1's admission nursing assessment dated [DATE] revealed Resident #1 was alert and oriented to person, place and time. Resident #1 required one person assist with toileting and ambulation with a device. Fall risks identified included fear of falling/muscle weakness/decreased lower extremity joint function/balance deficit or gait deficit and medication use. Interventions included encouraging Resident #1 to wear appropriate footwear as needed, keeping the environment as safe as possible, Physical Therapy/Occupational therapy (PT/OT) evaluate and treat as ordered and as necessary, providing Resident #1 with activities that minimized the potential for falls while providing diversion and distraction, and placing the call light in reach and encouraging its use. Review of Resident #1's physician orders revealed an order dated 07/14/25 for non-skid strips to the left side of the bed for fall intervention and an order dated 07/17/25 to ensure placement of brightly colored tape to the call bell. During observations with Registered Nurse (RN) #180 on 08/07/25 a 8:57 A.M., RN #180 verified Resident #1 did not have non-skid strips placed on the floor to the left side of his bed and did not have brightly colored tape on his call bell. This deficiency represents non-compliance investigated under Master Complaint Number 1270229 (OH00167232) and Complaint Number 1270228 (OH00166463).</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Based on observations, policy review, and interview, the facility failed to implement appropriate infection control practices during medication administration and incontinence care. This affected one (Resident #9) of seven residents observed for medication administration and one (Resident #84) of one resident observed for incontinence care. Findings include: On 08/06/25 between 9:00 A.M. and 9:16 A.M., Licensed Practical Nurse (LPN) #140 was observed preparing and administering medication to Resident #84. While preparing medication a famotidine 20 milligram (mg) tablet (used to reduce stomach acid production) was dropped on the floor. LPN #140 picked the medication up off the floor and disposed of it. Hand hygiene was not performed. LPN #140 continued to prepare and administer the other four medications (duloxetine 20 mg which is an anti-depressant, florastor 250 mg which is a probiotic, olmesartan 20 mg used to treat high blood pressure and oxycodone IR 5 mg which is a pain medication) to Resident #84. During the medication administration, LPN #140 was observed touching items in Resident #84's environment including the bed control and touching Resident #84 in an attempt to assist her to a more seated position. No hand hygiene was completed. After exiting Resident #84's room, LPN #140 proceeded to walk to the other side of the facility to the medication storage room in order to obtain a famotidine tablet. After obtaining the medication, LPN #140 returned to the medication cart where she proceeded to prepare it for administration. LPN #140 then entered the room and administered the famotidine to Resident #84. While administering the medication to Resident #84, her roommate (Resident #68) was calling out for help stating there was something in her eyes. After administering the famotidine, LPN #140 went to the linen cart and retrieved linens to clean Resident #84's eyes without performing hand hygiene. On 08/06/25 at 9:18 A.M. before LPN #140 could use the linens for Resident #68 she was stopped and verified she had not performed hand hygiene after picking the famotidine tablet up off the floor. Review of the facility's Medication Administration policy (last revised 10/17/23) revealed instructions to follow infection control practices. This included performing hand hygiene after direct resident contact. 2. On 08/07/25 at 10:30 A.M., Certified Nursing Assistant (CNA) #160 was observed providing perineal care to Resident #84. While cleaning Resident #84, CNA #160 was observed cleansing the pelvic area and shaft of the penis by using the same area of the washcloth to make multiple wipes in the same area. After cleaning the pelvic area, Resident #84 was turned to clean his buttocks. CNA #160 used the same area of the washcloth to cleanse the buttocks starting in the coccygeal area and cleaning downward with multiple swipes. After completing the incontinence care, Resident #84's bed control was used to adjust the bed prior to gloves being removed and hand hygiene being completed. On 08/07/25 at 10:45 A.M., CNA #160 verified she had made multiple wipes with the same area of the washcloth and cleansed from the coccygeal area downward when providing care. This deficiency represents non-compliance investigated under Complaint Number 1270228 (OH00166463).</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>(continued on next page)</p>

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to maintain a sanitary, clean and comfortable environment for all residents. This affected residents residing in 10 of 13 rooms observed, involved one of two resident shower/bathing rooms and had the potential to affect all 81 residents residing in the facility. Findings include: On 08/06/2025 between 11:20 A.M. and 12:17 P.M. observations of random rooms throughout the facility with Housekeeping Supervisor #190 revealed the following concerns which were verified by the supervisor at the time of the observation: Handrails in the hallway outside the dining room and office areas were observed being used by multiple unidentified residents as they propelled themselves to the main dining room. The inside ledge of the handrails were dusty with some debris observed. This was verified by the Administrator at the beginning of the tour. room [ROOM NUMBER] had dirt observed around the baseboard while entering the room. In the bathroom, a bag with a brief was observed under the sink counter. One brief was observed on the floor in the same area. Tissues were observed on floor. There was a large black discoloration on the floor at the right side of the base of the toilet. Interview with Housekeeping Supervisor #190 at the time of the observation verified this and stated the facility had tried to clean the discoloration unsuccessfully. There was splatter on the wall to the right of the toilet. Housekeeping Supervisor #190 indicated she could not state what caused the splatter or what it was. In Resident #46's room, Housekeeping Supervisor #190 verified the bathroom floor was stained and verified Resident #46's over bed table was dirty. room [ROOM NUMBER] was observed to have stains on the bathroom floor and there was staining noted on the wall under the bathroom sink. room [ROOM NUMBER] was observed to have discoloration on the floor on both sides of the toilet. In Resident #77's room the bathroom floor was stained and there was a urine collection container behind the toilet on the floor. The trash can by Resident #77's bed was filled over the top. Housekeeping Supervisor #190 indicated it was the responsibility of both housekeeping and nursing to empty trash cans when full. In Resident #82's room there was a yellow discoloration to the bathroom floor and Resident #82's over bed table was dirty. Housekeeping Supervisor #190 stated dirt in the window sill came from a plant Resident #82 used to have but was unable to state when the plant was removed from the window sill. The 300 hall spa had a thick dark yellow discoloration noted on the tiles of the floor and wall off the shower to the right of the room. A black discoloration was noted on the corner where the two walls met at the base of the shower. Housekeeping Supervisor #190 verified the discoloration and stated it appeared to be soap build-up. Resident #74 had an unused wheelchair in his room with a large dirt streak on the backrest which would come into contact with the resident's back and the cushion area was dirty. The top of the resident's dresser was dirty and the bathroom floor was discolored. On 08/06/25 at 11:47 A.M., the Administrator approached stating she understood there were concerns about the stained bathroom floors. The Administrator indicated there had been talks with corporate about addressing the stained areas. However, there were no definitive plans at that time on doing the repairs, purchasing the required materials, or a plan on time frames as residents had to be removed from their rooms for the day while the repairs were made. Continuation of the environmental tour with Housekeeping Supervisor #190 revealed the following: In room [ROOM NUMBER] there was a hole in the bathroom floor linoleum and rust spots on the floor by the toilet. In Resident #30's room there was discoloration of the bathroom floor as well as a trash can in the bathroom that was overflowing with wet paper towels on the floor by the trash can and trash under Resident #30's bed. In room [ROOM NUMBER] the bathroom floors were stained. During the course of the room inspections, Housekeeping Supervisor #290 reported two housekeepers were scheduled each day and they tried to get to every room on a daily basis. However, dependent on how many rooms needed deep cleaned, this was not always able to be done. The supervisor revealed the goal was to ensure each room was cleaned at least every other day. This deficiency represents non-compliance investigated under Master Complaint Number 1270229 (OH00167232).</p>		